Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

State of Rhode Island

Submission Date:	March 27,2006

CMS Receipt Date *(CMS Use)*	Electronic version received March 27, 2006

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
This is an application for a five year renewal of Rhode Island Waiver 0162.90.R2 that serves persons with Developmental Disabilities.

Application for a §1915(c) Home and Community-Based Services Waiver

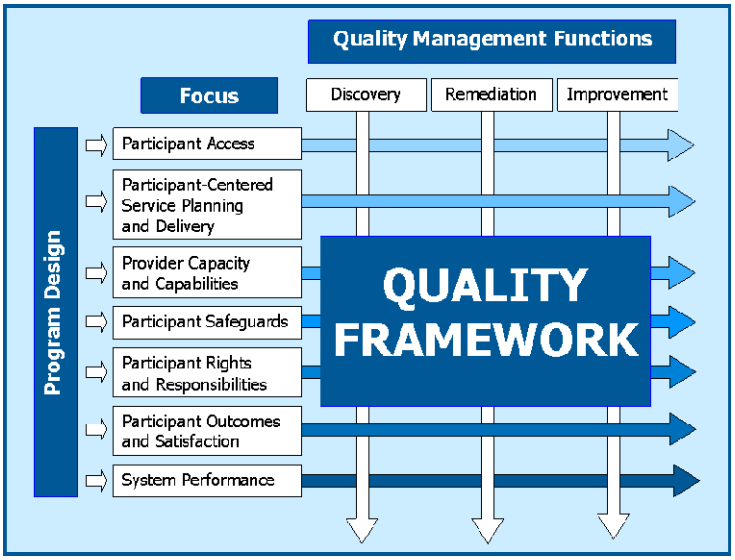
PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- **Participant Access**: *Individuals have access to home and community-based services and supports in their communities.*
- **Participant-Centered Service Planning and Delivery**: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve quality.*



The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.

1. Request Information

A. The **State** of **Rhode Island** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (*optional*):

C. Type of Request *(select only one)*:

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
x	**Renewal (5 Years) of Waiver #**	0162.90.R2	
○	**Amendment to Waiver #**		

D. Type of Waiver *(select only one)*:

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
x	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: 7/1/2006

E.2 Approved Effective Date *(CMS Use):* 7/1/06 **#0162.90.R3**

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*	
	○	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
☐	Nursing Facility *(select applicable level of care)*	
	○	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
x	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
x	Not applicable			

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Goals of the Waiver are:

- To address the needs of individuals with developmental disabilities at the ICF/MR level of care in the community;
- To provide comprehensive efficient and cost-neutral services that are responsive to the unique needs of each participant;
- To provide services that will result in measurable progress towards achieving personally established goals;
- To allow participants to set their own goals, take reasonable risks, manage their own lives and create a system of services that is responsive to their own personal needs
- To ensure quality management that focuses on health and safety, protection of participant rights, achievement of participant selected goals, and strives to both monitor and improve the system of services.

The waiver is administered by the **Rhode Island Department of Mental Health, Retardation and Hospitals (MHRH)**, which is responsible for:

1. Approval and monitoring of service plans based on functional assessment and participant preference.
2. Determination of level of care and Developmental Disability status.
3. Approval of all participant yearly funding levels
4. Ongoing monitoring of provider performance, participant satisfaction and outcomes, and quality indicators.

The Department of Human Services (DHS) as the Medicaid agency is responsible for:

1. Administrative oversight of MHRH functions pertaining to the waiver and waiver participants.
2. Participant waiver and Medicaid eligibility determinations and calculations of post-eligibility treatment of income, when applicable.
3. Fiscal oversight and monitoring.
4. Verifies annual completion of level of care

Services are delivered by providers licensed by applicable state authority (see Services section) and through a participant-directed model.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

x	The waiver provides for participant direction of services. *Appendix E is required.*
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. **Appendix H** contains the Quality Management Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

x	Yes
○	No
○	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
x	**No**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The Quality Consortium for the Division of Developmental Disabilities provided input during the development of this waiver renewal. The Consortium includes representatives including people with disabilities, family members, community agencies, state departments, advocacy and private organizations and staff from the Division of Developmental Disabilities (DDD) and the Department of MHRH. Approximately forty- five individuals are currently involved with the Consortium

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the

State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Dianne
Last Name	Kayala
Title:	Chief, Family Health Systems
Agency:	Rhode Island Department of Human Services
Address 1:	Division of Health Care Quality, Financing and Purchasing, Center for Adult Health
Address 2:	600 New London Avenue
City	Cranston
State	Rhode Island
Zip Code	02920
Telephone:	401-462-6303
E-mail	Dkayala@dhs.ri.gov
Fax Number	401-462-6339

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Ronald
Last Name	Lebel
Title:	Director
Agency:	Rhode Island Department of Human Services
Address 1:	600 New London Avenue
Address 2:	
City	Cranston
State	RI
Zip Code	02920
Telephone:	401-462-2121
E-mail	rlebel@dhs.ri.gov
Fax Number	401-462-3677

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

○	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*):
	○ The Medical Assistance Unit *(name of unit)*:
	○ Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)
x	The waiver is operated by **RI Department of Mental Health, Retardation and Hospitals, Division of Developmental Disabilities** a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*

2. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Medicaid Agency uses the following to ensure that MHRH, DDD, performs its assigned waiver operational and administrative functions in accordance with waiver requirements.

- The Long-Term Care Offices within the Medicaid Agency ensure that the individuals meet the financial requirements of the Waiver and that a Level of Care determination, signed by the Division of Developmental Disabilities, is included in their records.
- The Medicaid Agency works in partnership with the Division of Developmental Disabilities for any system modifications or enhancements to the MMIS.
- The Medicaid Agency approves all rates developed by the Division of Developmental Disabilities before they are transmitted to the Fiscal Agent.
- The Medicaid Agency has immediate access to all expenditure information for waiver services.
- The Medicaid Fiscal Agent reviews waiver claims submitted to the MMIS as part of its benefits analysis for all Medicaid recipients.
- Waiver claims are submitted to the Attorney General Medicaid Fraud Unit for investigation as appropriate.
- The Medicaid Agency participates in Agency Reviews conducted by the Division of Developmental Disabilities as described in the Quality Management section and is a member of the Quality Management Committee.

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (s*elect one)*:

○	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
x	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(check each that applies)*:

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
x	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	☐	x	x	☐
Assist individuals in waiver enrollment	☐	x	☐	☐
Manage waiver enrollment against approved limits	☐	x	☐	☐
Monitor waiver expenditures against approved levels	x	x	☐	☐
Conduct level of care evaluation activities	☐	x	☐	☐
Review participant service plans to ensure that waiver requirements are met	☐	x	☐	☐
Perform prior authorization of waiver services	x	x	☐	☐
Conduct utilization management functions	x	x	☐	☐
Recruit providers	☐	x	☐	☐
Execute the Medicaid provider agreement	x	☐	☐	☐
Determine waiver payment amounts or rates	x	x	☐	☐
Conduct training and technical assistance concerning waiver requirements	x	x	☐	☐

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Included	Target Group/Subgroup	Minimum Age	Maximum Age	
			Maximum Age Limit: Through age –	No Maximum Age Limit
○	**Aged or Disabled, or Both**			
☐	Aged (age 65 and older)			☐
☐	Disabled (Physical) (under age 65)			
☐	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
☐	Brain Injury			☐
☐	HIV/AIDS			☐
☐	Medically Fragile			☐
☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			o
x	Developmental Disability			x
☐	Mental Retardation			o
○	**Mental Illness**			
☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

b. Additional Criteria. The State further specifies its target group(s) as follows:

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

x	Not applicable – There is no maximum age limit
○	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

x	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c*.
○	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*. The limit specified by the State is *(select one)*:
	○ [ ] %, a level higher than 100% of the institutional average
	○ Other *(specify)*:
○	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c*.
○	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c*.
	The cost limit specified by the State is *(select one)*:
	○ The following dollar amount: $ [ ]
	The dollar amount *(select one)*:
	○ Is adjusted each year that the waiver is in effect by applying the following formula:
	○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
	○ The following percentage that is less than 100% of the institutional average: [ ] %
	○ Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4192
Year 2	4192
Year 3	4192
Year 4 (renewal only)	4192
Year 5 (renewal only)	4192

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

x	The State does not limit the number of participants that it serves at any point in time during a waiver year.
○	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

x	**Not applicable**. The state does not reserve capacity.
O	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

x	The waiver is not subject to a phase-in or a phase-out schedule.
O	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

x	Waiver capacity is allocated/managed on a statewide basis.
O	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

There are no waiting lists for this waiver

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

x	§1634 State
○	SSI Criteria State
○	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)				
☐	Low income families with children as provided in §1931 of the Act			
x	SSI recipients			
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121			
x	Optional State supplement recipients			
x	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*			
	x	100% of the Federal poverty level (FPL)		
	○	%	of FPL, which is lower than 100% of FPL	
x	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)			
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)			
x	Medically needy			
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*				
○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.			
x	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5*.			
	○	All individuals in the special home and community-based waiver group under 42 CFR §435.217		

	x	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:				
		x	A special income level equal to (select one):			
			x	300% of the SSI Federal Benefit Rate (FBR)		
			○	%	of FBR, which is lower than 300% (42 CFR §435.236)	
			○	$	which is lower than 300%	
		☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)			
		x	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)			
		☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)			
		☐	Aged and disabled individuals who have income at: *(select one)*			
			○	100% of FPL		
			○	%	of FPL, which is lower than 100%	
		☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

○	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
	○ Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.*
	○ Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
x	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):				
	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	100 %		of the Federal poverty level
		Other (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	

X	The following formula is used to determine the needs allowance:
	100% of the Federal Poverty level plus $20 for non-working individuals. 100% of the Federal Poverty level plus $20 plus all earned income. Earned income not to exceed 300% of the SSI monthly benefit rate. This applies only to individuals whose employment is in accordance with their plan of care.

ii. Allowance for the spouse only (*select one*):

O	SSI standard		
O	Optional State supplement standard		
X	Medically needy income standard		
O	The following dollar amount:	$	If this amount changes, this item will be revised.
O	The amount is determined using the following formula:		
O	Not applicable *(see instructions)*		

iii. Allowance for the family *(select one)*:

O	AFDC need standard		
x	Medically needy income standard		
O	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
O	The amount is determined using the following formula:		
O	Other (specify):		
O	Not applicable (see instructions)		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

x	The State does not establish reasonable limits.
O	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ % of the FBR, which is less than 300%
    - ○ $ which is less than 300% of the FBR
  - ○ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ○ The following standard under 42 CFR §435.121
- ○ Optional State supplement standard
- ○ Medically needy income standard
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The amount is determined using the following formula:
- ○ Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*

- ○ AFDC need standard
- ○ Medically needy income standard

○	The following dollar amount: $ [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ % of the FBR, which is less than 300%
    - ○ $ which is less than 300%.
  - ○ 100 % of the Federal poverty level plus $20
  - ○ Other (specify):
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ○ The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

  Specify the amount of the allowance:
  - ○ SSI standard
  - ○ Optional State supplement standard
  - O Medically needy income standard
  - ○ The following dollar amount: $ If this amount changes, this item will be revised.
  - ○ The amount is determined using the following formula:
- ○ Not applicable

iii. Allowance for the family *(select one)*:

○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ ____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	

	○	Other (specify):	
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		

ii. Allowance for the spouse only (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	○	The following standard under 42 CFR §435.121:	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount:	$ If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
○	Not applicable		

iii. Allowance for the family *(select one)*

○	AFDC need standard	
○	Medically needy income standard	
○	The following dollar amount: $	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:	
○	Other (specify):	
○	Not applicable (see instructions)	

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)*:			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
○	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
○	Other (*specify*)**:**		
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*			
○	Allowance is the same		
○	Allowance is different. Explanation of difference:		
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:			
a. Health insurance premiums, deductibles and co-insurance charges. b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*			
○	The State does not establish reasonable limits.		
○	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.		

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):* One	
ii.	**Frequency of services**. The State requires *(select one)*:	
	○	The provision of waiver services at least monthly
	x	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○	Directly by the Medicaid agency
x	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
○	Other (*specify*):

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Level of care evaluations and reevaluations are performed by the Division of Developmental Disabilities case manager or a registered nurse, licensed by the State. Case Managers are either Qualified Mental Retardation Professionals (QMRP), as defined in 42 CFR 483.430 (a), or are supervised by a Qualified Mental Retardation Professional. All Levels of Care are approved by the Division of Developmental Disabilities and verified by the Medicaid agency.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

In order for an individual to be determined to need waiver services, the individual must, due to a developmental disability, meet at least one of the following factors which include:

1. Person previously lived in an ICF/MR facility, or
2. Person previously was a participant in the CSLA program, or
3. Person requires ICF/MR Level of Care due to:

- inadequate supports to maintain current living situations,
  - Living with one parent or family member, OR
  - Living with parent or family member over age 60; OR
  - Severely or profoundly retarded/developmentally disabled (total care), OR
  - Severe behavior problem (intervention more than once per hour).

Individuals may receive funding for one service or multiple services under the waiver based on their need for support and the choices that the individual and family make regarding services and supports. Services are usually provided at least weekly, although in some situations, the services may be less than monthly. In such instances, such as Respite, Specialized Medical Equipment and Supplies, or Home Modifications, the case manager will monitor the individual and family situation to assure that necessary services are available to enable the individual to maintain their living situation. All waiver services are documented in the plan of care through a prior authorization from the Division of Developmental Disabilities or the Medicaid Agency. The process is the same for both the initial evaluation and the annual reevaluations which are completed effective July 1 of each year. The "Client Certification/Recertification for Title XIX Waiver," which includes the at-risk criteria indicated above, forms the basis for the Level of Care determination (CP1) is forwarded to the Medicaid Agency for review, and is included in the current Waiver. These instruments are maintained at the Medicaid Agency and within the Division for at least three years.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

x	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
O	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The case manager/RN meets with the individual and any party requested by the individual to evaluate functional need and any risk factors as listed in the assessment tool.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

O	Every three months
O	Every six months
x	Every twelve months
O	Other schedule (*specify*):

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

x	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
O	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

Evaluations are due July 1 of every year regardless of entry date to the waiver. The Division ensures that all forms are completed by this date, and the Medicaid verifies completion.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records are maintained at the Operating Agency.

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

At the time of the initial evaluation, individuals and their families are notified of their right of choice of waiver services or institutional care and their options for services within the waiver. The family signs a "Notification of Recipient Choice" form (CP-12B). This form is maintained by the Medicaid agency.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Forms are maintained by the Medicaid Agency for at least three years.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The Division has some case managers that are bi-lingual. In the event a person needs a translator, the Division has access to translation services through a Master Price Agreement with the State Division of Purchases. In addition, the Division also has the ability to access a translator for individuals whose primary means of communication is not language.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	x	
Home Health Aide	☐	
Personal Care	x	
Adult Day Health	☐	
Habilitation	x	
Residential Habilitation	x	Residential Supports
Day Habilitation	x	Day Supports
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	x	
Education	☐	
Respite	x	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
X	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Adult Foster Care (Supported Living Arrangements)
b.	Personal Emergency Response System

c.	Specialized Medical Equipment
d.	Environmental Accessibility Adaptations
e.	Private Duty Nursing
f.	
g.	
h.	
i.	

Extended State Plan Services *(select one)*	
X	Not applicable
O	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
c.	

Supports for Participant Direction *(select one)*	
X	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
O	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	x	Supports Facilitator
Financial Management Services	x	

Other Supports for Participant Direction *(list each support by service title)*:	
a.	Participant Directed Goods and Services
b.	
c.	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
x	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

State of Rhode Island employees under the Division of Developmental Disabilities conduct case management activities

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-*(select one)*:

x	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	a) All direct service personnel are investigated at the b) state level as c) verified at regular agency evaluations
○	**No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

x	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	The RI Department of Health maintains a registry of professional and paraprofessional licensure violations (RN, Rehabilitation, CNA) that must be checked by home health agencies prior to hiring personnel. This requirement is verified at the time of routine Home Health Agency Licensure visits by the Department of Health.
○	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
x	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Group Home	Residential Supports	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Group homes typically have a capacity to serve between 3-6 persons with developmental disabilities. The majority of new residential development over the last five years in RI have been homes serving 4-6 people, although there is not a required limit in regulation. Homes are generally located in residential communities throughout the state and they reflect the building style and landscaping of other homes in the neighborhood. People with disabilities are involved in choosing the furnishings and decorations for homes. Bedrooms are individualized and reflect the individual tastes and personal interests of each individual. In most homes a couple of individuals would have their own bedroom and a few people would share a bedroom with another person. People have the opportunity for privacy within the homes.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type Group Home	Facility Type	Facility Type	Facility Type
Admission policies	x	☐	☐	☐
Physical environment	x	☐	☐	☐
Sanitation	x	☐	☐	☐
Safety	x	☐	☐	☐
Staff : resident ratios	☐	☐	☐	☐
Staff training and qualifications	x	☐	☐	☐
Staff supervision	x	☐	☐	☐
Resident rights	x	☐	☐	☐
Medication administration	x	☐	☐	☐
Use of restrictive interventions	x	☐	☐	☐
Incident reporting	x	☐	☐	☐
Provision of or arrangement for necessary health services	x	☐	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Note: Staff/resident ratios are not specifically included within the current Licensing requirements. The Agency Certification Agreement requires all agencies to submit sample staffing patterns which are reviewed by Division staff to assure that the number of staff is adequate to meet the needs of people to be served.

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

x	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians**. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
○	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
x	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	Relatives who do not reside with the participant and who meet all provider qualifications may provide services to the participant. The individuals must be hired by a qualified provider, or in the case of participant-directed services verified by the fiscal agent to meet qualifications. Accurate payment for services is assured through the service utilization review process. The Division of Developmental Disabilities verifies that payments are only made for services in the approved ISP, and the Medicaid Fiscal Agent only processes claims for people with active waiver status on the dates of service. Division Agency Reviews and the Medicaid Fiscal Agent Ultilization Review process assure that the services were provided as billed.

○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Any entity wishing to become a provider may apply to the Department of Mental Health, Retardation and Hospitals for licensure and certification as a Developmental Disability Agency. If all licensure and certification qualifications are met, the provider is added to the Division's website and to participant materials as an agency that can be chosen to provide waiver services. Each provider must complete a provider enrollment with the Medicaid agency prior to providing services or billing Medicaid.

Appendix C-3: Waiver Services Specifications

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable) and can be found on the MHRH and Health websites.

Service Specification	
Service Title:	Homemaker

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

x	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Home Health Agency
				Home Health Nursing Agency

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	x	Relative *not residing with participant*

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health	State Dept of Health		
Home Nursing	State Dept of Health	Medicare	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health	**Medicaid Agency Fiscal Agent**	**Annual**
Home Nursing	**Medicaid Agency Fiscal Agent**	**Annual**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Personal Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

x	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Personal Care Services are direct support in the home or community to individuals in performing tasks they are functionally unable to complete independently due to disability, based on the Individual Service Plan. Personal Care Services include:

- Participant assistance with activities of daily living, such as grooming, personal hygiene, toileting bathing, and dressing
- Assistance with monitoring health status and physical condition
- Assistance with preparation and eating of meals (not the cost of the meals itself)
- Assistance with housekeeping activities (bed making, dusting, vacuuming, laundry, grocery shopping, cleaning)
- Assistance with transferring, ambulation; use of special mobility devices

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Home Health Agency
				Home Health Nursing Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	x	Relative *not residing with participant*

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health	State Dept of Health		
Home Nursing	State Dept of Health	Medicare	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health	**Medicaid Agency Fiscal Agent**	**Annual**
Home Nursing	**Medicaid Agency Fiscal Agent**	**Annual**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Residential Supports

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

x	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in their own home and a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance (where applicable), or upkeep and improvement.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications

Provider Category(s) *(check one or both)***:**	x	Individual. List types:	x	Agency. List the types of agencies:
	Participant/Representative Directed		DD Services and Supports Agency	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	x	Relative *not residing with participant & at least 18 years of age*

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual			Criminal Background Check, age 18
Agency	MHRH	Division of DD	Certified for residential supports

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	**Waiver Fiscal Agent**	**At Hire**
Agency	**Medicaid Fiscal Agent**	**Annual**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Day Supports

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

x	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day supports focus on enabling the individual to attain or maintain his/her maximum functioning level and are coordinated with any other services identified in the person's individual plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications

Provider Category(s) *(check one or both)***:**	x	Individual. List types:	x	Agency. List the types of agencies:
	Participant/Representative Directed		DD Services and Supports Agency	

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	x	Relative *not residing with participant*

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual			Criminal Background Check, age 18
Agency	MHRH	Division of DD	Certified to provide day supports

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	**DD Fiscal Agent**	**At Hire**
Agency	**Medicaid Agency Fiscal Agent**	**Annual**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Supported Employment

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

x	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision, transportation and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications

Provider Category(s) *(check one or both)***:**	x	Individual. List types:	x	Agency. List the types of agencies:
	Participant/Representative Directed		DD Services and Supports Agency	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	x	Relative *not residing with participant*

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual			Criminal Background Check, age 18
Agency	MHRH	Division of DD	Certified to provide supported employment

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	**DD Fiscal Agent**	**At Hire**
Agency	**Medicaid Fiscal Agent**	**Annual**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Respite

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

x	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications

Provider Category(s) *(check one or both)***:**	x	Individual. List types:	x	Agency. List the types of agencies:
	Representative Directed		DD Services and Supports Agency	

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	x	Relative *not residing with participant*

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual			Criminal Background Check, age 18
Agency	MHRH	Division of DD	Certified to provide respite

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	**DD Fiscal Agent**	**At Hire**
Agency	**Medicaid Fiscal Agent**	**Annual**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification					
Service Title:	Supported Living Arrangements				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
x	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
○	Service is not included in the approved waiver.				
Service Definition (Scope)**:**					
Personal care and services, homemaker, chore, attendant care, companion services and medication oversight (to the extent permitted under State law) provided in a private home by a principal care provider who lives in the home. Supported Living Arrangements are furnished to adults who receive these services in conjunction with residing in the home. Separate payment will not be made for homemaker or chore services furnished to an individual receiving Supported Living Arrangements, since these services are integral to and inherent in the provision of adult foster care services.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
None					

Provider Specifications				
Provider Category(s) *(check one or both)***:**	x	Individual. List types:	x	Agency. List the types of agencies:
	Supported Living Arrangements Provider		Certified DD Agency	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Supp.Living Provider			Meets Division Contracting Standards, age 18, criminal background check
DD Agency	MHRH	Division of DD	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
(Supported Living Arrangements Provider)	**Division of Developmental Disabilities**	**Annual**
DD Agency	**Division of Developmental Disabilities**	**Annual**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Personal Emergency Response System

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

x	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				PERS approved agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
PERS Agency	Business Regulations		Meets Medicaid contracting standards, RIGL Title 56

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
PERS Agency	**Medicaid Agency**	**Enrollment & if complaint**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Specialized Medical Equipment

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

x	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Specialized Equipment and Supplies are devices, controls, or appliances specified in the ISP, which enables the participant to improve the ability to perform activities of daily living, or to perceive, control or communicate with the environment in which they live. The ISP will also clearly indicate a plan for training the participant, family, and/or primary caregiver on the use of the requested equipment. This service also includes ancillary supplies and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Medicaid Plan, necessary to avoid institutionalization and shall exclude those items, which are not of direct benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Prior approval on an individual basis shall be obtained for all items.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				DME Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DME Provider	Business Regulations		RIGL Title 56

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
DME Provider	**Medicaid Fiscal Agent**	**Annual**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Environmental Accessibility Modifications

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
x	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Those physical adaptations to a private home and/or vehicle, required by the individual's service plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and community, and with out which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home or vehicle which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Licensed Contractors and/or DME Providers

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Contractor	Business Regs		RIGL Title 56
DME Provider	Business Regs		RIGL Title 56

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Contractor	**Medicaid Fiscal Agent**	**Annual**
DME Provider	**Medicaid Fiscal Agent**	**Annual**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification					
Service Title:	Private Duty Nursing				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
○	Service is included in approved waiver. There is no change in service specifications.				
○	Service is included in approved waiver. The service specifications have been modified.				
x	Service is not included in the approved waiver.				
Service Definition (Scope)**:**					
Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law and as identified in the ISP. These services are provided to an individual at home					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
None					

Provider Specifications				
Provider Category(s) *(check one or both)***:**	x	Individual. List types:	x	Agency. List the types of agencies:
	RN or LPN licensed in RI		Home Health Agency	
			Home Health Nursing Agency	

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	x	Relative *not residing with participant*

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual	RN or LPN		Criminal Background check, professional abuse registry check, 18 and over
Home Health	Dept of Health		
Home Nursing	Dept of Health	Medicare	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	**DD Fiscal Agent**	**At Hire**
Home Health	**Medicaid Fiscal Agent**	**Annual**
Home Nursing	**Medicaid Fiscal Agent**	**Annual**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Fiscal Management Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
x	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Assist the participant in allocating funds as outlined in the Individual Service Plan and facilitate employment of staff by the participant. Services include reimbursing individual providers on behalf of the participant, acting as a payroll agent for the participant, providing a monthly expenditure report to the participant detailing expenditures of funds against their pre approved budget, providing the participant with the results of statewide criminal background checks for all persons providing direct care for the participant and statewide criminal background checks for all appointed representatives, and reporting if any person providing direct care to a program participant appears on the statewide healthcare professional abuse registry as maintained by the Rhode Island Department of Health. Also verifies driver's license and insurance of PCAs who may be transporting a participant. The Fiscal Agent also provides the information and skills trainings needed to manage one's own care in the areas of rights and responsibilities of both the participant and worker; recruiting and hiring workers; developing schedules and outlining duties; supervising and evaluating workers; how to access the services and goods identified in the Individual Service and Spending Plan; managing the monthly budget, assists with completion of necessary paperwork and, helps the participant ensure that his/her rights and safety are protected.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Meets Medicaid and MHRH contracting standards

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Fiscal Intermediary	MHRH	DDD	Medicaid Contracting Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Fiscal Intermediary	**Medicaid Agency**	**BiAnnual**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Supports for Consumer Direction (Supports Facilitation)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
x	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Focuses on empowering participants to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the participant through the service planning and delivery process. The Facilitator counsels, facilitates and assists in development of an Individual Service Plan which includes both paid and unpaid services and supports designed to allow the participant to live in the home and participate in the community. A back-up plan is also developed to assure that the needed assistance will be provided in the event that regular services identified in the Individual Service Plan are temporarily unavailable.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications

Provider Category(s) *(check one or both)***:**	x	Individual. List types:	☐	Agency. List the types of agencies:
	Facilitator			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	x	Relative *not residing with participant*

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Support Broker			Meets DD Contracting Standards, criminal background check, age 18 or older

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Support Broker	**Division of DD**	

Service Delivery Method

Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	Participant Directed Goods and Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
x	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Participant Directed Goods and Services are habilitative or theraputic services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that addresses an identified need and is in the MHRH approved Individual Service Plan (including improving and maintaining the individual's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR the item or service would increase the individual's ability to perform ADLs or IADLs; AND/OR increase the person's safety in the home environment; AND, alternative funding sources are not available. Individual Goods and Services are purchased from the individual's self-directed budget through the fiscal intermediary when approved as part of the ISP. Examples include a laundry service for a person unable to launder and fold clothes or a microwave for a person unable to use a stove due to his/her disability. This will not include any good/service that would be restrictive to the individual or strictly experimental in nature.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications

Provider Category(s) *(check one or both)***:**	x	Individual. List types:	x	Agency. List the types of agencies:
	Selected by participant		Licensed Business	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	x	Relative *not residing with participant*

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual			As specified by participant, criminal background check & age 18 or over
Agency	Business Regs		RIGL Title 56

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	**DD Fiscal Agent**	**Time of service**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	☐	Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies)*.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.*
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*
x	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*
	Each participant receives an assessment that measures functional, social, health and behavioral criteria. A funding level for all services is determined that is based on historical cost and risk factors. New participants are notified in writing of their funding level, and have the opportunity to appeal if he/she believes that the level does not support his/her service needs. If there are changes in their individual status the division will reassess their need for support and adjust the funding level to meet newly identified needs.
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
☐	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Individual Services and Supports Plan (ISSP)

a. **Responsibility for Service Plan Development**. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
☐	Case Manager (qualifications specified in Appendix C-3)
	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
	Qualified Mental Retardation Professional (QMRP) or supervised by QMRP
☐	Social Worker. *Specify qualifications:*
X	Other (*specify the individuals and their qualifications):*
	The Plan is developed by the individual chosen by the person with a disability, and/or their family. In most cases, the Plan is developed by the person, family member, and the provider agency selected by the person. The person with a developmental disability and/or their family could also develop a Plan through a Fiscal Agent for participant directed services.

b. Service Plan Development Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:
	The DDD social case worker reviews the individual plan for completeness to meet the needs of the person based on the Personal Capacities Inventory (PCI) and Situational Assessment. DDD social caseworkers receive copies of all plans developed by provider agencies and those submitted by individuals involved in participant directed services..

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as

appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

All newly eligible persons are provided with a brochure describing services/supports available from the Division and a list of certified and licensed agencies for them to select an appropriate provider. Each person is assigned a social caseworker who assists the individual in contacting different agencies to assist them in making a decision to select a provider and to discuss the service plan development process. Informational materials (Booklet "*Questions To Ask In Looking For A Service Provider"*) and personal contacts (PAL Family Organization) are available to people to assist them in the provider selection process and in the development of their Service Plan.

The MHRH Licensing regulations stipulate that the person is responsible for determining who "shall assist him/her in the development of his/her Plan and can include any individual he/she chooses".

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Initially all newly eligible people are assessed by the Division using the Personal Capacities Inventory (PCI) and Situational Assessment tools to identify specific needs and support of the person in the areas of self-direction, communication, mobility, learning, work/day activities, capacity for independent living and any needs for additional specialized or intensive support. Other pertinent documents and information is reviewed in order to determine a level of funding for the person.

The DDD social caseworker assigned to the person with a disability informs him/her and/or his/her family of services available under the waiver, through other funding sources and through generic services.

The individual with developmental disabilities chooses who he/she wants to develop his/her plan and who else should participate in the process.

The MHRH Licensing regulations requires that the Plan include an individualized profile of the person highlighting their capabilities, preferences and interests; a personalized statement of the person's expectations for the future; address natural supports and connections for people with other citizens of the community; a description of the needs of the person and who the person would like to meet those needs; state who will be responsible for providing services/supports; include a back-up plan in the event of a health or personal emergency where staff/resources are not available on a 24 hour basis; and include personal satisfaction indicators.

Depending on services provided to the person the agency would be responsible for completing appropriate assessments in the area of Health Care, Psychology, PT/OT, Speech, Supported Employment, etc. and for reviewing this information prior to the individual planning meeting.

At a minimum, the person and the provider agency complete the development of the Plan. The planning meeting may include the person's assigned social caseworker, family, friends, individuals from the community and other agency representatives. The Plan includes the signatures of people participating in the development of the Plan.

The agency is responsible for identifying staff responsible for implementing the Plan and for determining the process for monitoring the Plan. DDD social caseworkers monitor general service delivery.

The DDD social caseworker completes a review of the finalized Plan for consistency with the PCI and Situational Assessment in terms of meeting the person's needs for services/support.

Plans may be revised when the needs of the person significantly change. Typically plans are updated and reviewed annually

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The Situational Assessment and PCI tools identify general areas of potential risk and the need for specialized or intensive support for the person which are incorporated into the Service Plan. Many provider agencies have their own tool for assessing the safety needs of the person which is discussed at the planning meeting with the person and included in the Plan as necessary.

Back up plans are required to be addressed for any one who does not have 24 hour staff. Provisions for back up for a health or personal emergency must be included in the Plan, as required by the MHRH Licensing regulations.

The Health and Safety Committee of the Quality Consortium has been working on the development of a *Risk Assessment and Planning Tool* to be available, when finalized, to agencies to utilize as a resource. Currently the tool is being field tested by a number of community agencies.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The DDD social caseworker provides information to individuals with developmental disabilities and their families about licensed and certified providers. The MHRH website also includes this information.

Other resources are available to people from the Division and from the statewide Advocates in Action agency to assist people to select a provider.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

In July of each year a service plan is completed by the DDD social case worker on each person with a developmental disability. The form lists the specific services to be provided, the provider agency(cies) and authorization period. The completed form is sent directly to Medicaid agency within DHS.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
x	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
x	Operating agency
☐	Case manager
☐	Other (*specify):*

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The provider agency is responsible to coordinate, implement and monitor services that are identified within the Plan and the health and safety of the person.

The Division of Developmental Disabilities (DDD) conducts *Agency Reviews* which includes a component for the random selection of individual records including individual Service Plans. The Agency Review process involves a qualitative monitoring of the services identified in the Plan in terms of the actual services provided to the person, his/her level of satisfaction and fiscal accountability. In addition, personal interviews with the person may occur. Typically an *Agency Review* would include the review of 10-15 records/Plans per agency. Agencies are required to respond to any recommendations made relating to the Review in a formal response indicating the action to be taken, person responsible and timeframes for completion.

The PAL organization has a contract from the department to annually conduct 400 personal interviews with people receiving services from the Division. Individual plans are reviewed as well as background information prior to the interview. Individual reports are completed and sent to the agency and DDD social caseworker for follow up, as necessary.

b. Monitoring Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:
	The *Agency Review* process does include a review of the monitoring completed by the agency in terms of persons responsible, progress/status notes, assessments, and other reports relating to the implementation of the Plan.

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]
Applicability *(select one)*:

x	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
○	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

○	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
x	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The waiver is designed to afford the opportunity to elect to direct waiver services. Alternate service delivery methods are available for individuals who decide not to direct their services. They can receive guidance from their State Case Manager who will introduce individuals interested in administering their own plan to the agency that provides the fiscal management services. This agency will meet with the individual and their families and provide them with information related to what it means to administer their own plan. The agency is available to answer any questions the individuals /families have before they make their choice of their service delivery method.

If an individual chooses to administer their own plan, they have both the employer authority and the budget authority. The fiscal management agency will support them in completing all necessary forms to become the employer of record, and to assure that expenditures are made in conformance with the approved budget and necessary documentation of expenditures are maintained. Supports Facilitators can be used to assist in the development of an individualized plan and budget if an individual chooses to use one.

The State provides for the direction of waiver services by a representative. This representative can be the legal representative of the individual or a non-legal representative freely chosen by the person. A support facilitator will assist the participant/representative in developing the plan and budget if requested. The individual's plan and budget is submitted to

the Division for approval. The individual's Case Manager, a Program Administrator, and the Financial Office review these documents. Recommendations regarding program content is made to a Program Review Committee who decides whether to authorize the services. Once authorized, the fiscal management agency reviews expenses submitted to them for payment for adherence to the approved budget. Should the fiscal intermediary have concerns that are not addressed by the individual or representative, they are brought to the State Case Manager and/or the Division's financial office.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
x	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

x	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
x	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	Waiver is designed to support only individuals who want to direct their services.
x	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Any person selecting participant direction at Case Management meetings is referred to a DD Agency certified to provide fiscal intermediary functions as well as more traditional DD services. The agency meets individually with the participant, any other person the participant selects, and his/her representative (when applicable) to detail requirements and responsibilities including written materials. The fiscal agent also informs the participant about the available support brokers from which he/she chooses to aid in plan development when needed. MHRH approves all spending plans prior to implementation.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

○	The State does not provide for the direction of waiver services by a representative.	
x	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:	
	x	Waiver services may be directed by a legal representative of the participant.
	x	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		The fiscal management agency monitors expenditures and notifies the Operating Agency in the event an individual's budget spending patterns indicate concern. The fiscal management agency is a fully licensed agency and follows all reporting protocols established for the waiver as outlined elsewhere.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Residential Supports	x	x
Day Supports	x	x
Supported Employment	x	x
Respite	x	x
Specialized Medical Equipment	☐	x
Environmental Modifications	☐	x
Fiscal Intermediary	☐	x
Private Duty Nursing	x	x
Supports Facilitator	x	x
Participant Directed Goods and Services	x	x

Homemaker Services	☐	X
Personal Care	☐	X
Personal Emergency Response Service	☐	X

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

x	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*	
	☐	Governmental entities
	x	Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*	

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

x	FMS are covered as the waiver service entitled as specified in Appendix C-3.	Fiscal Management Services
○	FMS are provided as an administrative activity. *Provide the following information:*	
	i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:
	ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
	iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*
		Supports furnished when the participant is the employer of direct support workers:
		☐ Assist participant in verifying support worker citizenship status
		☐ Collect and process timesheets of support workers
		☐ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
		☐ Other *(specify):*
		Supports furnished when the participant exercises budget authority:
		☐ Maintain a separate account for each participant's participant-directed budget
		☐ Track and report participant funds, disbursements and the balance of participant funds
		☐ Process and pay invoices for goods and services approved in the service plan

	☐	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other services and supports *(specify)*:
	Additional functions/activities:	
	☐	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	☐	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other *(specify):*
iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
x	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: **Fiscal Management and Supports Facilitator**
☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

k. Independent Advocacy *(select one)*.

x	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
	All program applicants are provided with contact information for the RI Disability Law Center at intake and each annual review
○	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

People wanting to transfer to traditional service delivery need only request the switch, and will be transferred.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

A person who has been found to be at risk of harm or who has consistently made poor decisions on budget expenditures despite intervention by the fiscal management agency would be transferred to traditional agency services. Incident management is handled in the same way as for all other waiver participants.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		120
Year 2		120
Year 3		120
Year 4 (renewal only)		120
Year 5 (renewal only)		120

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:*
x	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

x	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
x	Hire staff (common law employer)
x	Verify staff qualifications
☐	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
☐	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
☐	Determine staff duties consistent with the service specifications in Appendix C-3.
x	Determine staff wages and benefits subject to applicable State limits
x	Schedule staff
x	Orient and instruct-staff in duties
x	Supervise staff
x	Evaluate staff performance
x	Verify time worked by staff and approve time sheets
x	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply***:**

x	Reallocate funds among services included in the budget
x	Determine the amount paid for services within the State's established limits
x	Substitute service providers
x	Schedule the provision of services
x	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
x	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
x	Identify service providers and refer for provider enrollment
x	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Each participant receives an assessment that measures functional, social, health and behavioral criteria. A budget for all services is determined that is based on historical cost and risk factors. New participants are notified in writing of their funding level. If there are changes in their individual status the division will reassess their need for support and adjust the funding level to meet newly identified needs. The same budget setting methodology is used for participant directed service plans as is used for non-participant directed service plans under this waiver.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant is notified in writing of their allocated budget amount. If the person cannot purchase the services within the budgetary amount he/she can appeal.

iv. Participant Exercise of Budget Flexibility. *Select one:*

x	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
	The fiscal agent monitors spending and tracks service plan changes. Because the fiscal agent is also a full scope licensed MHRH provider, the agent must follow all Division required reporting procedures, including report whenever there is any concern of health and safety due to a proposed change in the budget allocation.
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The fiscal agent is responsible for tracking expenditures and intervening and reporting to the Division whenever excess funds are depleted or when the individual is underutilizing authorized services.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Agencies are responsible for determining the most appropriate strategy for informing people with developmental disabilities of their human rights and ensuring that individuals understand their rights to the best of their ability to do so. Each person is informed of his/her rights annually and have their signed statement of human rights reviewed with them including the availability of free legal assistance. Each person is also provided with the name and telephone number of the Chairperson of the Human Rights Committee.

A notice of the right to appeal is included in all Medicaid notices and provided to all applicants at intake and at their annual review.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

○	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
X	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

X	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Department of Mental Health, Retardation and Hospitals (MHRH).

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The MHRH Licensing regulations (*DD 16 Grievances*) and RI Law Chapter 40.1-26-5 *Participant Grievance Procedure* require all agencies to have a written grievance procedure to be utilized to process any type of complaint by people with disabilities, their legal guardians or advocates. The notice of the grievance procedure must include the names of organizations that provide free legal assistance (RI Disability Law Center). Forms are available within specified locations in the agency. Staff assistance is available to the person in exercising his/her right to file a grievance.

The agency is required to annually explain the grievance procedure to the person in a manner in which the person understands which could include using various approaches such as verbal communication, written or graphical formats, audio or videotapes, etc.

The individual initiates the grievance by filing a grievance form with the Executive Director of the agency who is responsible for forwarding a copy of the completed form to the Chairperson of the Human Rights Committee.

The Executive Director of the agency or his/her designee along with the Chairperson of the Human Rights Committee (HRC) or his/her designee is required to investigate and try to resolve the grievance. A written decision on the conclusion of the review of the grievance must be provided to the person with developmental disabilities or their legal guardian or advocate within five business days of receipt of the grievance.

If the individual is not satisfied with the decision made by the agency Executive Director and the Chairperson of the Human Rights Committee he/she has the right to appeal that decision under regulations promulgated by the department of MHRH at an administrative hearing.

Appendix G: Participant Safeguards

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

RI Law (*40.1-27-2 Duty to Report*), MHRH Licensing regulations (*DD 15 Reporting Requirements*) and the "*Requirements for Reporting Serious Incidents Involving Adults with Developmental Disabilities"* policy document developed by the Office of Quality Assurance (QA), Division of Developmental Disabilities (DDD), MHRH, specifies the types of incident classifications that must be reported to the Office of QA, DDD.

Any individual who has knowledge of or reasonable cause to know or suspect that a serious incident has or may take place must report that information to the Office of QA/DDD within 24 hours or at the end of the next business day. The Incident Management Office in QA is staffed Monday through Friday from 8:30 am to 4:00 pm to directly respond to each incident reported. There is a 24 hour telephone number to call and access to a 24 hour pager in QA for emergency situations that occur after normal work hours that may need to be immediately addressed.
The types of incidents that must be reported to the Office of QA, DDD include the following:

- Physical Abuse
- Sexual Abuse
- Sexual Exploitation
- Psychological/Verbal Abuse
- Theft/Financial Exploitation
- Neglect
- Mistreatment
- Unapproved Behavioral Intervention
- Aversive Procedures
- Serious Injury
- Hospitalization
- Serious Medication error
- Communicable Disease
- Suicide
- Death
- Missing Person
- Human Rights Violation
- Involvement of Law Enforcement
- Confidentiality Violation

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives,

as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

RI has a strong statewide advocacy organization, *Advocates in Action*, that has been providing educational programs and information directly to people with disabilities and self-advocacy groups for many years. Numerous materials have been developed in this area along with various videotapes. Advocates in Action has demonstrated leadership and initiative in sponsoring Partners in Policymaking programs, annual conferences and various workshops to assist people to learn more about their human rights, to live safely in local communities and to have a good quality of life.

People with disabilities assist staff from the Office of Quality Assurance, DDD, conduct various training programs for individuals with developmental disabilities at community agencies on understanding their human rights and protection from abuse. A booklet on *Human Rights* was developed in 2003 by people with disabilities to disseminate as part of this training. In addition a magnet with various important telephone numbers from the Division including the Office of QA along with a Liberty pin "*You Have Rights*!" is distributed to each participant in the training. Training is provided to any agency or organization that requests assistance in this area. Using people with disabilities as part of the training has been very beneficial to agencies and the training has been well received by participants attending the training.

The Office of QA has a brochure *"Abuse and Serious Incidents Must Be Reported"* and a flyer *"Report Abuse*" that has been extensively disseminated with community agencies and to some family members. Additional work is being planned to determine more specific strategies to provide this information to family members statewide.

PAL, a statewide family advocacy organization, along with the RI Developmental Disabilities Council, the RI Arc and the RI Disability Law Center have provided assistance and information to families about their rights and protections from abuse involving their family member through newsletters, training programs and technical assistance.

MHRH Licensing Regulations (DD 13 Staff Training) require that all staff from licensed community agencies be trained in the following areas:

- *Human Rights and the Roles/Responsibilities of the Office of QA/DDD*
- *Detection and Prevention of Abuse, Neglect, Mistreatment and Other Serious Human Rights Violations*
- *Procedures for Reporting Allegations of Abuse or other Human Rights Violations to the Office of Quality Assurance, DDD*
- *Teaching Strategies to Assist people to Learn the Specific Skills they Need*

The licensing regulations (*DD 7 Human Rights*) stipulate that agencies are responsible for determining the most appropriate strategy for informing people with developmental disabilities of their human rights and ensuring that people understand their human rights. Each person is at a minimum informed of his/her rights at their annual planning meeting and signs a *Statement of Human Rights* that is typically included in the person's individual record. Many agencies have developed very creative materials in this area including booklets with graphics and photos, videotapes and materials developed specifically for individuals who are deaf.

Human Rights Committees (HRC) also have responsibility for ensuring people with disabilities

and their families are educated about their rights and understand the role/responsibilities of the HRC to assist them with grievances and to have input in the agencies policies to prevent abuse and promote human rights.

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Each reported incident is documented on the Office of Quality Assurance's *Confidential Incident Report Form* and entered weekly into the Division of developmental Disabilities' computerized Incident Tracking System. RI Law and MHRH Licensing regulations require that information on serious reportable incidents must be shared with the Office of the Attorney General and the chairperson of the agency's Human Rights Committee which is typically done within 24 hours.

All reported incidents are reviewed and discussed at a bi-weekly DDD Incident Management Committee that includes a multidisciplinary team of professional staff from the Office of Quality Assurance, Office of Health Care, and Social Services, DDD. The purpose of the Incident Management Committee is to review all incidents, which have been reported to classify each one based on the information reported, identify any further information necessary, to ensure that each incident has been responded to appropriately and to identify trends for quality improvement across the delivery service system. The committee is responsible for determining whether there is sufficient information available to classify the incident, what additional information may be necessary to obtain from the reporter or provider agency, and whether any formal action/assignment is required such as submission of further information, completion of a specific form or a formal QA Review or Investigation. Any request for additional information is documented on the *"Incident Review Follow Up Form*" and tracked on a computerized data base maintained by the Office of QA.

Staff from the Office of Quality Assurance, DDD, are trained to conduct or coordinate investigations. Specific individuals from licensed community agencies are trained and authorized to conduct investigations. Approximately 400 individuals have participated in formal investigations trainings sponsored by the Office of QA. Investigations are typically assigned to a trained individual within 24 hours of the incident being reported. The Office of QA typically investigates serious incidents of abuse and assigns trained investigators from community agencies to investigate other types of incidents. If a community agency has been authorized by QA to conduct the investigation then a staff person from QA will be assigned to coordinate the investigation to provide technical assistance and guidance to the agency investigator throughout the investigation process. All investigations are conducted utilizing a standardized process and format for the final investigation report. RI Law requires investigations to be completed within 15 working days, however, this timeframe is difficult to meet in most situations. Generally, investigations are completed within 4-8 weeks. Agencies are required to submit a *Quality Improvement Plan* within 15 working days for any investigation in which the allegation has been substantiated or inconclusive.

Information on each reported incident is also immediately shared with the Office of Office of Facilities, Program Standards and Licensure, MHRH, for any follow up action as determined necessary. Copies of all reported incidents are shared with the department's Investigation Panel which is responsible for reviewing and tracking all serious reported incidents.

All deaths are immediately reported to the Office of Health Care, DDD, by staff from QA along with a copy of the completed incident report. All deaths are reviewed by the Division's Mortality Review Committee which is responsible for identifying issues, concerns and trends; requesting more information regarding a death on the *Mortality Reporting and Review Form*; reviewing information provided by the agency; and specifying recommendations, as necessary. The Committee is chaired by the Administrator of the Office of Health Care and includes administrative staff from the Office of Quality Assurance, Social Services, Community Support, Office of Health Care and the medical director, DDD. Staff from the Office of Health Care are responsible for reviewing the completed *Mortality Forms* and requesting additional information as necessary, maintaining a database and developing a report of findings and recommendations to the Committee. Staff also provide technical assistance to the Office of QA for deaths which are formally being investigated by reviewing and assessing information provided relating to the individual.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Office of Quality Assurance, DDD, is the designated office responsible for overseeing the reporting of and response to serious reportable incidents involving adults with developmental disabilities. The Office of QA is within the Division of Developmental Disabilities which is one of the programmatic divisions in the state Department of Mental Health, Retardation and Hospitals (MHRH).

Formal investigations that are conducted for serious reportable incidents result in a confidential written Investigative Analysis report which is shared with the Office of the Attorney General, as necessary and an Investigative Analysis Findings report which is shared with the agency Executive Director, Board President and Chairperson of the Human Rights Committee. A cover letter signed by the administrators of the Office of QA, DDD, and the Office of Facilities, Program Standards and Licensure, MHRH, is sent to the agency with the report with a requirement for completion of a written *Quality Improvement Plan* within 15 working days and notification of possible licensing action, as necessary.

Information on each reported incident is immediately shared by the Office of QA with the Office of Facilities, Program Standards and Licensure, MHRH, for any licensing action or follow-up, as necessary. The Office of Facilities, Program Standards and Licensure, MHRH, has taken licensing action with some agencies as a follow-up to serious incidents reported to QA and completed investigations.

An *Incident Management Trends Analysis Committee* provides a broader perspective on reported incidents and initiates more proactive response to incidents. The Committee meets quarterly and reviews data from aggregate reports relating to reported incidents. Members of the committee include staff from the Office of Quality Assurance, Office of Health Care, Office of Community Support (Social Services) and the Office of Information Technology in the Division of Developmental Disabilities as well as staff from the Office of Facilities, Program Standards and Licensure and the Office of the Director, MHRH. The committee is chaired by a staff person from the Office of Quality Assurance, DDD. The

meetings focus on trends seen across the DDD service delivery system as well as those indicated by the individual agencies. In 2004 participation on the committee was expanded to include representatives from various provider agencies, the Developmental Disabilities Council, the Disability Law Center and the RI Arc in an effort to obtain more diversified perspectives and to share information publicly relating to aggregate data on serious reportable incidents and system trends. The committee is responsible for reviewing prepared reports by the Office of Quality Assurance and Information Technology on all types of incidents reported to QA, to identify system trends, to make recommendations which could have an impact on reducing and/or preventing incidents from occurring in the future and for system improvement and to advise the Executive Director on any major issues or concerns.

The Division designed an *Agency Review* protocol in 2001 for monitoring/valuating the effectives of services provided by community agencies. The tool designed was modeled after the CMS protocol and includes the following areas:

- *Individual Record Review-Program Areas*
- *Individual Record Review-Health Care*
- *Provider Qualifications*
- *Incident Management*
- *Fiscal Review*

The process for an Agency Review involves a multi disciplinary team of staff from the DDD who participate in the Agency Review that typically takes 1-3 days. Each team member is responsible for reviewing various components of programs/services and for writing a section of the Final Report that is formally sent to the agency. The Incident Management component of the Review includes a review of the policies/procedures of the agency in the areas of incident reporting, incident management, investigations and staff training; a random review of internally reported incidents and serious reportable incidents to the Office of QA; review of follow-up action by the agency for incidents in which the allegation has been substantiated or inconclusive; and review of the agency's incident management process and Incident Management Committee minutes, documentation of any recommendations of the Incident Management Committee and documentation of follow through on the recommendations.

The agency is expected to respond to the Final Report within twenty working days with a written response to each recommendation including action to be taken, staff responsible and timeframes for completion.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed.

a. Applicability. *Select one:*

○	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions *(do not complete the remaining items)*	
x	This Appendix applies. Check each that applies:	
	x	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
	x	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete items G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Agencies are required to specify any and all restraints used in their Behavior Management Policy and Procedure Manual, which is submitted to the state for approval. The Agency is required to review the manual annually and submit any changes to the state for approval. They are also required to specify the manner in which staff will be trained, the curriculum that will be followed and the credentials of the trainer. Physical restraint is to be used only with graduated guidance and the least level of force necessary to keep the individual safe. It may only be employed as a last resort in situations of imminent danger to the individual and/or other people. Mechanical Restraint may only be employed for individuals with whom physical restraint is not safe. Both procedures require the approval of the Agency Director, Physician, Human Rights Committee, and Professional Review Committee (an external body of 3 clinicians approved by the state and determined to have no allegiance to the agency or other conflict of interest). Plans that contain these procedures are scrutinized by the Professional Review Committee, and every attempt is made to decrease restrictiveness, utilize positive approaches, and determine the cause of the dangerous behavior in order to teach the individual new skills and replacement behaviors. **Seclusion is prohibited by Law RIGL 40.1-26-3.** Medication used for restraint is required to be prescribed by a Licensed Healthcare Provider. The Department of MHRH's Health and Wellness Standards also require that "All medication and treatment orders be reviewed and renewed annually and as otherwise indicated by the licensed Healthcare Provider."

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of MHRH Division of Developmental Disabilities (MHRH/DDD) Office of Community Support is responsible for overseeing the use of restraint. Seclusion is prohibited by law, RIGL 40-1-26-3. Oversight is accomplished through the requirement that every individual with a behavior intervention plan containing a restraint procedure be reviewed and approved at least annually by a Professional Review Committtee (PRC). The PRC has the discretion to require more frequent review in any case where there is cause for concern. Procedures may NOT be employed without PRC approval, and if a plan does not meet PRC approval, MHRH/ DDD is notified and intervenes until safe and effective resolution is reached. Any unauthorized use of restraint is reported to the DDD Office of Quality Assurance, and is investigated. Agencies submit a **Quarterly Report of Restrictive Procedures** to the DDD Office of Community Support, as well as an Agency **Annual Restraint Report.**

c. Safeguards Concerning the Use of Restrictive Interventions

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The MHRH Licensing Regulations (Sections DDBI 21-26) are highly prescriptive with the level of justification and scrutiny required in cases where restrictive procedures must be employed due to the dangerousness or severity of a given pattern of behavior(s). Chapter 26, 40.1 of RI General Law prohibits many aversive interventions, and in conjunction with the above referenced regulations, specifies many conditions, analysis', timeframes, training, data, multiple authorizing signatures and external review and approval of both a Professional Review Committee (PRC), and Human Rights Committee (HRC).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of MHRH/DDD Office of Community Support is responsible for this function. This is done in conjunction with the independent Professional Review Committees (PRCs) described above. Quarterly reports evidencing the PRC review and approval status of every specifically described restrictive intervention are provided by the agencies to the DDD Office of Community Support.

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

x	**Yes**. This Appendix applies *(complete the remaining items)*.
○	**No**. This Appendix is t applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The Office of Quality Assurance within the Department of Mental Health, Retardation and Hospitals' (MHRH) Division of Developmental Disabilities (DDD) has the responsibility to investigate or cause to be investigated all serious medication errors.

The Division of Developmental Disabilities' Incident Management Committee meets twice each week to review all incidents that have been called in to the Office of Quality Assurance. The Incident Management Committee includes staff from the Office of Quality assurance, Office of Health Care and Social Services, DDD.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The MHRH Licensing Regulations require that licensed developmental disabilities provider agencies report serious incidents. The definition of "serious incidents" in the MHRH Licensing regulations and in the DDD/Quality Assurance Reporting Requirements includes Medication Errors. A reportable medication error is defined as "the administration of a medication or treatment other than as prescribed, or the failure to administer a prescribed medication or treatment, resulting in the need for assessment/treatment in an emergency room, treatment center, physician's office, or admission to a hospital. A reportable medication error also includes a series of repeated errors or a pattern of errors."

The MHRH Licensing Regulations require provider agencies to "complete and maintain written incident reports documenting any abuse, neglect, mistreatment, violation of a person's human rights, or other serious incident. Licensed developmental disabilities provider agencies are required to have an Internal Incident Review Committee that meets at minimum on a quarterly basis to review all incidents reported to DDD Quality Assurance.

The *Health and Wellness Standards* section of the MHRH Licensing Regulations requires that "If medication errors or omissions occur, the nature of the error or reason for the omission shall be documented according to the agency's written policy and procedure". The *Health and Wellness Standards* also require that "all medication and treatment orders shall be reviewed and renewed annually, and as otherwise indicated by the licensed health care provider".

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

X	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
○	Not applicable (*do not complete the remaining items*)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The *Health and Wellness Standards* section of the Department of Mental Health, Retardation and Hospitals' (MHRH) Licensing Regulations describes the requirements for training and competency assessment for Direct Support Staff (unlicensed personnel) administering medications. Additionally, the *Health and Wellness Standards* require licensed developmental disabilities provider agencies to have a written policy and procedure describing medication safeguards and support protocols for individuals who self-administer their medications.

iii. Medication Error Reporting. *Select one of the following:*

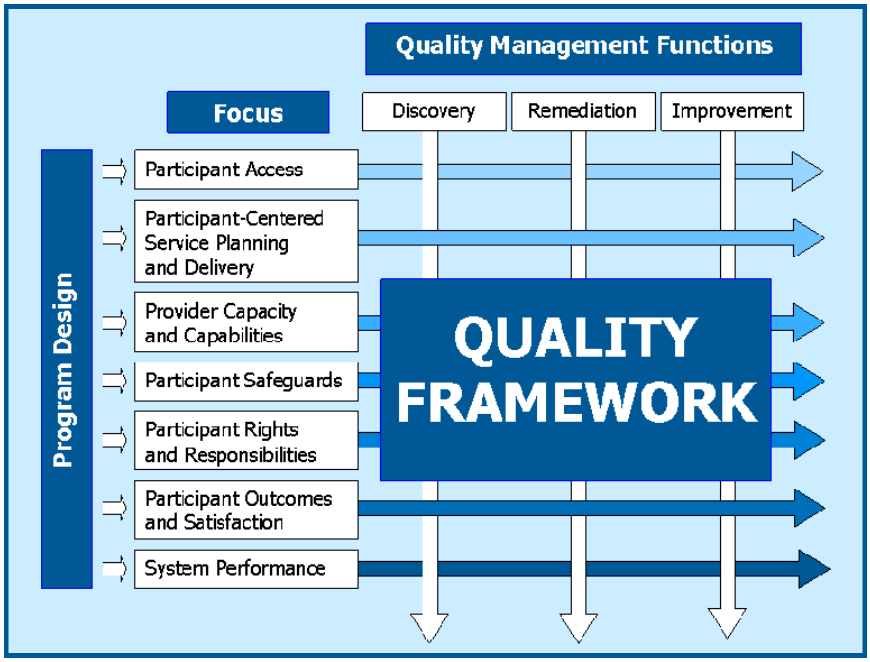
X	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	The Department of Mental Health, Retardation and Hospitals' Division of Developmental Disabilities/Office of Quality Assurance.
	(b) Specify the types of medication errors that providers are required to *record:*
	Medication errors as defined in Section b (ii).
	(c) Specify the types of medication errors that providers must *report* to the State:
	Medication errors as defined in Section (b) ii.
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The medication administration requirements described within the *Health and Wellness Standards* will be monitored during the course of provider agency licensing surveys conducted by the Department.

Appendix H: Quality Management Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.



Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy**.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

The State of Rhode Island is committed to ensuring the health and safety of people with developmental disabilities receiving services, promoting promising practices to continue to enhance service delivery, and offering the highest quality services that promote choice and control in people's everyday lives. RI has a long history of collaborative relationships with people with developmental disabilities, family organizations, community providers and other statewide advocacy organizations in developing and providing comprehensive community based services and supports.

Responsive to customer feedback and analysis of various data collection activities, the Quality Management Strategy measures, addresses and enhances quality of life, services and supports and organizational practices within the system for people with developmental disabilities and their families in Rhode Island.

Rhode Island's Quality Management Strategy includes systems and approaches to collect and analyze information in various areas (*discovery*); to provide technical assistance and program development to agencies or to initiate formal requests/action, as necessary (*remediation*); and a primary focus to measure and improve overall system performance (*quality improvement).*

RI has a number of initiatives that are included within our Quality Management Strategy including the following:

A. Participation in the National Core Indicators (NCI) Project

The National Core Indicators (NCI) Project is a collaboration among 25 participating NASDDDS member state agencies and the Human Services Research Institute (HSRI), with the goal of developing a systematic approach to performance and outcome measurement. Through collaboration, participating states pool their resources and knowledge to create performance monitoring systems, identify common performance indicators, work out comparable data collection strategies, and share results.

RI provides annual data to NCI in the following areas:

- ***Consumer Outcomes*** (RI contracts with PAL, a statewide family organization, to conduct 400 individual surveys annually with people with developmental disabilities to ask specific questions relating to services provided and involvement of the person with employment, inclusion, self-determination, choices, relationships, decision-making, and service coordination. Trained interviewers meet personally with the individuals to conduct the interview and to complete an individual report. Copies of the completed individual surveys are shared with the agency for any necessary action and the state social case worker for their information and immediate follow up, as necessary. PAL also develops an *Annual Report of Trends* that summarizes the findings of all of the completed surveys and identifies areas of excellence and areas for potential improvement. This

Report is widely disseminated throughout the state with provider and advocacy organizations and has been shared with the RI Statewide Quality Consortium. In addition,the Division includes data of the summary results from a few of the questions from the Consumer Survey in the Performance Measures in the Division's budget document which is shared with the RI Legislature.)

- ***Health, Welfare and Rights*** (The Office of Quality Assurance, DDD, is responsible for providing state system data annually to NCI relating to health, restraints, serious reportable incident data, and Mortality Review. This information is generated from information/forms provided to the Division by community agencies and from information on serious reportable incidents that is required to be reported to the Office of Quality Assurance within 24 hours by community agencies. The Division has established a Mortality Review process to collect more specific information relating to deaths to be reviewed by a multi-disciplinary team of professional staff from the Division.)

NCI staff summarize the results of all information provided to them by all participating states annually in Final Reports which are shared with each state are included on their website. These reports are an opportunity for RI to compare ourselves with other states using specific benchmarks The annual report developed by NCI is widely disseminated in RI to provider and advocacy organizations.

B. Statewide Quality Consortium

The Office of Quality Assurance (QA), DDD, conceptualized the idea of a statewide ***Quality Consortium*** to directly involve key stakeholders from various organizations in reviewing and analyzing data and information, discussing initiatives and brainstorming strategies to make quality improvements within the system of services/supports for people with developmental disabilities in Rhode Island. Individuals on the Consortium represent a diversity of perspectives and an incredible wealth of knowledge and expertise.

The Consortium includes representatives from people with disabilities, family members, community agencies, state departments, advocacy and private organizations and staff from the Division of Developmental Disabilities (DDD) and the Department of MHRH. Approximately forty- five individuals are currently involved with the Consortium.

The purpose of the Quality Consortium is to bring together representatives from various organizations to work collaboratively to:

- Identify various ongoing projects/activities that collect or have collected information (PAL Quality of Life Project, DDD's Continuous Quality Improvement (CQI), Incident Management, DD Council satisfaction project, etc.)
- Review various data/information regarding services, satisfaction, outcomes
- Identify trends within the system
- Make recommendations for quality improvement

Val Bradley, President of HSRI in MA, assists the Consortium in reviewing data and trends from reports generated and in areas of national trends to facilitate discussion to identify priorities for system improvement.

Members of the Quality Consortium review summary data from reports generated from a variety of sources such as Licensing, Incidents, Mortality Review, NCI Project, DD Council Initiatives, CQI Project, etc. and identify trend areas within system for quality improvement. The Council identified three major areas for committee work:

- *Employment*
- *Health and Safety*
- *Relationships*

Members of the Consortium have provided input on the development of this waiver application through committee work and at the Consortium level.

The Consortium currently has three active committees which meet at least quarterly:

- *Employment* …responsible for developing an annual employment survey to collect data and specific information on people with disabilities working in jobs in RI, analyzing the results of the survey and making recommendations for system improvement, and developing resources and information for people with disabilities to improve their access to employment.
- *Health and Safety*…responsible for developing informational materials for families, identifying strategies to prevent incidents including the development of informational materials, developing a risk assessment and planning tool, and reviewing and recommending areas for staff training.
- *Incident Management Trends Analysis*…responsible for reviewing and analyzing aggregate data relating to serious reportable incidents reported to the Office of Quality Assurance, DDD, identifying trends, and establish priorities and recommendations for system improvement.

Another committee, *System Performance*, is beginning in spring 2006 to be responsible for reviewing all types of aggregate trend reports and source information to measure performance within the system such as the PAL Trends Report, licensing summaries, Agency Review Findings, CQI Summaries, etc. This committee will then report back to the Consortium an analysis on these various reports and recommendations for quality improvement within the system.

C. MHRH Licensing

The Office of Facilities, Program Standards and Licensing, MHRH, is responsible for conducting licensing reviews and surveys for all agencies providing services/supports to adults with developmental disabilities. These reviews are typically conducted every two years. In addition, Licensing does conduct some unannounced visits to agencies, as necessary. Agencies are required to submit a *Plan of Correction* to the Licensing office within 15 days regarding any deficiencies identified through the licensing survey. The *Plan* must identify action to be taken by the agency and timeframes for completion. The department has taken appropriate action in situations where the *Plan* is not acceptable.

In early 2005 the Department of MHRH initiated action to update the licensing regulations for community agencies providing services/supports to adults with developmental disabilities. The regulations had been promulgated in 1995 and needed to be revised to reflect more current practice in the field of disabilities. In late spring of 2005 the Department hosted three community meetings to solicit input from various provider and advocacy organizations on areas for clarification, revision and/or improvement within the

MHRH Licensing Regulations. In November 2005 the Department organized a statewide informational meeting and invited provider agencies, advocacy organizations, people with disabilities and family members. The purpose of the meeting was to announce the initiation of six licensing workgroups and to invite participation of various individuals on the workgroups.

The Workgroups were modeled after the *CMS Quality Framework Areas*:

1. *Access*
2. *Safeguards*
3. *Participant Centered Planning*
4. *Rights and Responsibilities*
5. *Provider Capacities and Capabilities*
6. *Outcomes and Satisfaction and System Performance*

Each workgroup includes people with disabilities, family members, provider agencies, advocacy organizations and staff from MHRH. The workgroups began meeting in early January, 2006, and meet twice monthly. Each workgroup is co-chaired by a staff person from MHRH and another individual representing people with disabilities, families, provider agencies or an advocacy organization. All workgroups received copies of the CMS Quality Framework, NQIP report, CARF standards, materials on Quality from the Council on Quality and Leadership and other background information to provide a foundation for the development of the new regulations.

The co-chairs of the workgroups are also part of a Departmental Steering Committee which meets monthly to share information on the status of work of each of the workgroups and to discuss any issues the committee needs feedback on. A first draft of the proposed regulations will be available in the spring of 2006.

In June 2004 the Department also promulgated *Licensing Process and Procedure Regulations* to create a uniform licensing process and procedure for all facilities and programs licensed by the Department of Mental Health Retardation and Hospitals. They were developed in furtherance of the Department's statutory mandate and responsibilities to those persons served through the various Divisions within the Department. The Regulations were designed to promote and safeguard adequate facilities and programs in the interest of public accountability, health, safety and welfare. The Department has utilized these new regulations to initiate Compliance Orders for immediate action necessary to protect the health, welfare and safety of people with disabilities. Staff from the Office of Facilities, Program Standards and Licensure and the Office of Quality Assurance, DDD, have monitored the implementation of actions taken by any agency that received a Compliance Order.

These regulations specify:

a) the evidentiary requirements for agencies to receive a license;
b) the types of license the department can issue *(Provisional*- issued to a new Organization that demonstrates compliance with administrative and policy regulations but has not demonstrated compliance with all the regulations, or *Conditional*- issued to an

organization that has demonstrated an inability to maintain compliance with regulations; has a serious violation of human rights or applicable regulations; has multiple violations of human rights or licensing regulations; has demonstrated conduct or practice found by the Director to be detrimental to the welfare of the persons served; or has failed to comply with a previous plan of correction.)

c) specific licensing actions/sanctions the department may take for any provider that is not in compliance with the regulations in order to protect the health and safety of people served by the agency,
d) the process for submitting Plans of Correction ,
e) conditions for suspension, revocation, curtailment and denial of a license, and
f) procedures for requesting an Appeal meeting.

D. Continuous Quality Improvement Project (CQI)

The CQI Project began in 1996 and was designed by an individual with a disability who was working for the Office of Quality Assurance, DDD, as a consumer advocate. The Project was developed as an initiative to determine the satisfaction of people with developmental disabilities with the services provided to them and their understanding of human rights, individual service planning, choices, and community involvement. To date, over thirty agencies have been reviewed using the CQI format. Agencies have responded positively to this project and have found the final report to be useful for strategic planning and in improving the quality of services.

The CQI Project is one way to look at the outcomes or the impact services/supports have on the lives of people with disabilities. A staff person from the Office of Quality Assurance, DDD, is identified as the lead staff person and two CQI Resource Specialists, who are individuals with a developmental disability, work collaboratively together for each CQI visit to a specific community agency.

The CQI Project involves a 2-5 day visit to an agency, which begins with an Administrative Interview. This involves a two-hour interview at the agency including the Executive Director and his/her administrative team; a representative from the Board of Directors, Human Rights Committee and self-advocacy; and an individual from Social Services, DDD.

The Executive Director of the agency is sent a copy of the format and process 3-4 weeks prior to the administrative meeting. People present for the meeting are asked to respond to the following four questions:

1. *What Is The Agency Doing Well?*
2. *What Are The Things That Need Improvement?*
3. *What Needs To Be Addressed Immediately?*
4. *What Are Some Good Ideas To Be Shared With Other Agencies?*

After the Administrative Interview is completed, the CQI team spends the next few days going on

site visits to various programs/homes. The agency staff are responsible for choosing the places visited and for organizing opportunities for the team to talk directly with people receiving supports from the agency. One to three focus groups with people with disabilities are also set up which generally last about an hour and a half.

The Focus Groups are led by the Resource Specialists and are organized to talk directly with people receiving supports, to ask them questions about their lives and their awareness or knowledge of such areas as:

- *Human Rights*
- *Choices/Supports*
- *Community Membership*
- *Opportunities*

The QA staff person and Resource Specialists develop a *Final Report* on the findings, observations and team recommendations, which is presented to the agency at a scheduled meeting. The agency responds to the *Final Report* by submitting a *Follow-up Form* typically within 30 days identifying what action will be taken to address any of the areas needing attention, who will be responsible and timeframes for completion.

E. Incident Management Trends Analysis Committee

An Incident Management Trends Analysis provides a broader perspective on reported incidents and to initiate work to move towards a more proactive response to incidents. The Committee meets quarterly and reviews data from aggregate reports relating to incidents formally reported to the Office of Quality assurance, DDD. The meetings focus on trends seen across the DDD service delivery system as well as those indicated by the individual agencies.

The Committee includes the following individuals from DDD and MHRH representing the Office of Community Support (Social Services), Office of Community Resource Development, Office of Health Care, Office of Information Technology, Office of Quality Assurance, DDD; and the Office of Facilities, Licensing and Standards, and Office of Investigations, MHRH. In 2005 the committee was expanded to include representatives from organizations outside of the department including the RI Disability Law Center, RI Developmental Disabilities Council, the RI Arc and the Community Provider Network of RI.

Purposes of the Committee:

1. To review and analyze aggregate information of incidents reported to QA and to identify trends from the types of incidents reported within the DDD service system and various agencies,

2. To make recommendations which could have an impact on reducing and/or preventing incidents and for systems improvement, and
3. To advise the Executive Director on any major issues/concerns.

Reports/Information Reviewed

- Aggregate number of incidents, investigations and dispositions reported quarterly
- Aggregate number of incidents, investigations and dispositions reported annually
- Incidents reported by individual agencies
- Summary of substantiated investigations and outcomes of investigations
- *Primary Causes* of investigated incidents

The Committee has been focusing its review and analysis in developing strategies for remediation and improvement in the following areas;

- Neglect
- Sexual Abuse
- Injuries/falls
- Psychiatric Hospitalizations

F. Agency Reviews

The Division of Developmental Disabilities (DDD) designed an *Agency Review* protocol in 2001 for monitoring/evaluating the effectiveness of services provided by community agencies. The tool designed as a checklist was modeled after the Center for Medicaid and Medicare Services (CMS) protocol and included the following areas:

A. Individual Record Review-Program Areas
B. Individual Record Review-Health Care
C. Provider Qualifications
D. Incident Management
E. Fiscal Review

A multi-disciplinary Team of individuals that now includes a DHS waiver program representative participate in the Agency Review which typically takes 1-3 days. Each member of the Team is responsible for reviewing various components of programs/services, sharing a summary of their findings with the agency staff at the end of the visit and for writing a section of the Final Report that is formally sent to the agency. Technical assistance is available and provided to agencies by the division or through identification of best practices implemented by other community agencies. RI has a long history of collaboration and information sharing among community agencies in order to improve service quality.

The Division recently completed an *Annual Report of Findings* on the agencies reviewed since 2002 which has been disseminated to the Statewide Quality Consortium and provider and advocacy organizations.

H. Statewide Training and Education

The Office of Health Care, DDD, was the coordinating entity for the development and promulgation in September 2005 of new *Health and Wellness Standards* that are part of the MHRH licensing regulations for community agencies. These new standards require competency based training and utilization of Health Care Orientation and Medication Administration Curriculums for all direct support staff of community agencies. The six modules of training will ensure that direct support staff have appropriate training to ensure the health and safety of people with developmental disabilities. The 35 hours of training is a combination of classroom and person specific training necessary to ensure competency.

The Office of Quality Assurance, DDD, conducts or coordinates statewide training and agency requested training in the areas of *Prevention of Abuse; Understanding the Roles/Responsibilities of the Office of Quality Assurance, DDD; Human Rights Education; Requirements for Reporting Serious Incidents; Sexual Assault Incident Management Model; Conducting Serious Incident Investigations; Investigators' Forums and Establishing Incident Management Committees.* Training is available for staff of community agencies as well as people with developmental disabilities and Human Rights Committee members. Each training program includes informational materials and other resources to assist staff to ensure the health and safety of people with disabilities and to improve service quality.

In addition the Community Provider Network of Rhode Island (CPNRI) also provides statewide training through the Direct Support Professional Training which is available to all new direct support staff as well as other types of training to improve management skills of administrative staff and enhance system quality.

I. DDD Strategic Plan

Staff from the Division have drafted a new Strategic Workplan document which identifies key areas for system improvement. The document has been shared and reviewed with the Statewide Quality Consortium and various advocacy and provider organizations for their input and feedback on the areas identified and their recommendations for priorities.

The document identifies specific issues and challenges for the next few years in the following areas:

1. *Service Delivery System Design*
2. *Administrative/Internal Issues*
3. *Linkages/Relationships with State Agencies, Providers and Other Organizations*

The plan will serve as a planning tool for the Division for system development and quality improvement activities.

J. MHRH Website

The Department does has an internal website for employees which includes more specific information

relating to the many of the above mentioned quality improvement initiatives. The MHRH external website is currently undergoing extensive redesign and is expected to be operational in the next month. The Department has already posted various reports and information mentioned above on the existing website (www.mhrh.ri.gov).

The Department is committed to identifying other alternative strategies to disseminate information in an effort to keep all stakeholders within the system informed about system findings and trends and activities for quality improvement.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Mental Health, Retardation and Hospitals, Division of Developmental Disabilities has an Agency Certification Document and Licensing Regulations that require an annual independent audit of agencies that receive funding for individuals with developmental disabilities. The audited Financial Statements, Management Letter, and additional schedules required by the Division are submitted yearly to the Division. The Auditor General for the State of Rhode Island conducts an annual Medicaid audit, the findings of which are forwarded to CMS.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

All rates for Residential and Day Supports, Adult Foster Care, Supported Employment, Respite, PERS, Fiscal Intermediary, Personal Care, Homemaking, Private Duty Nursing and Support Brokers are established through historical cost data and negotiation with providers. Specialized Medical Equipment, Environmental Modifications and Participant Directed Goods and Services rates are based on cost plus installation/service fee. The Division of Developmental Disabilities assigns a funding level amount to each participant based on an assessment of need that is then distributed amongst services established in the individual plan as decided by the participant and approved by the Division.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billing for personal care, homemaker, PERS, some specialized medical equipment and Environmental Modifications is made directly to the MMIS. Other billing is submitted by the Agency to the Division of Developmental Disabilities. There are edits within the Division's system to ensure that there is an authorization for the category of services on the claim, and there are sufficient funds within the authorization to pay the claim. The claim is then transmitted to the MMIS for payment, which includes verification that there is an active Waiver segment on file for the individual for the dates of service on the claim. The Department of Human Services and the Division of Developmental Disabilities are working on enhancements to the MMIS to incorporate prior authorization information, by individual, by type of service. Once completed, Agencies will bill the MMIS directly for all services. The Division also receives a monthly report of the dates of service for each individual, for each type of service. This report is checked against billing to ensure that services were provided for the period of the claim.

c. Certifying Public Expenditures *(select one)*:

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):
☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

	☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
x		**No**. Public agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Division of Developmental Disabilities verifies that payments are only made for services in the approved ISP, and the Medicaid fiscal agent only processes claims for people with active waiver status on the dates of service. Division agency reviews and the Medicaid fiscal agent service utilization review process assure that services were provided as billed.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

○	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
x	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
	The only payments not made through the MMIS are Respite and Adult Foster Care. The Division, with State funds, reimburses the provider for expenses related to respite. A claim is then charged to the Waiver for individuals who are authorized for the Waiver service based on the individual's utilization of the service. The waiver is charged for adult foster care (Supported Living Arrangements) when the payment is processed through the state of RI financial system. The Division of Developmental Disabilities maintains a full audit trail. Claim information is provided to the Medicaid agency through the State's financial management system for the CMS-64. The Division provides service and expenditure information to the Medicaid Agency for completion of the CMS 372.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

x	The Medicaid agency makes payments directly to providers of waiver services.
☐	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
x	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

	Participant-Directed services are paid through the fiscal intermediary and reimbursed by the Medicaid agency. The fiscal intermediary is responsible for ensuring that all paid services are within the participant's individual plan. The Medicaid agency reviews the fiscal intermediary biannually.
☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

x	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

x	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
	There is one public provider in Rhode Island, Rhode Island Community Living and Supports (RICLAS) that receives payment for Residential and Day Habilitation services. The rate methodology for the public provider is the same as the rate methodology for private providers for the same services.
○	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

x	The amount paid to public providers is the same as the amount paid to private providers of the same service.

○	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

x	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
x	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

x	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
	Fiscal Intermediaries are OHCDS's because they provide direct fiscal services to participants as detailed in Appendix C. They are certified by meeting IRS, MHRH and Medicaid certification standards (on file in the Medicaid agency). The Fiscal agent processes all self-directed personnel payroll functions, verifies that provider qualifications are met, and monitors the health and safety of participants directing their own services. The provider may elect to enter into a provider agreement with the Medicaid fiscal agent instead of with the OHCDS. In the event the Provider elects to enroll as a provider with the Medicaid fiscal agent, he/she will have to authorize release of the criminal background and abuse registry check (to the fiscal agent) and authorize payroll verifications and deductions (deducted by and reimbursed to the fiscal intermediary) as a condition of becoming a direct Medicaid provider. The OHCDS must submit reports of all transactions to participants and their Advisor, as well as verify the Criminal Background and Abuse registry screening and that minimum age requirements are met. Billing to the MMIS must also include expenditure details. MHRH will compare expenditures to service plan authorizations when conducting agency reviews. The participant is the common law employer of personal assistants. The OHCDS assists the participant in payroll, verifications and reporting only.
○	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required

	to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
x	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

☐	**Appropriation of State Tax Revenues to the State Medicaid agency**
x	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
	The State source of the non-federal share of computable waiver costs is from Rhode Island General Revenue, appropriated by the General Assembly to the Department of Mental Health, Retardation and Hospitals, Division of Developmental Disabilities. The Medicaid Fiscal Agent charges the Division's accounts directly for both the Federal and State funds in accordance with the prevailing matching requirements at the time the payment is issued. Revenue and expenditure information from the Division's accounts is immediately available to the Medicaid agency. There are no non-State level sources of funds for the non-federal share of waiver expenditures.
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

x	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
x	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
x	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Individuals in residential settings retain the full waiver community needs allowance to pay their room and board costs. The residences are only paid for services provided to participants, not living space and food cost.

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
x	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

x	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

	Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

x	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:							
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	77,967	4,946	82,913	184,650	4,212	189,446	106,533
2	79,427	5,292	84,719	197,576	4,507	202,083	117,364
3	83,386	5,662	89,048	211,406	4,822	216,228	127,180
4	84,141	6,058	90,199	226,204	5,160	231,364	141,165
5	85,050	6,482	91,532	242,038	5,521	247,559	156,027

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	4,192		
Year 2	4,192		
Year 3	4,192		
Year 4 (renewal only)	4,192		
Year 5 (renewal only)	4,192		

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

SFY 2005 average length of stay

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Per person waiver cost in SFY 2005 with inflator added based on historical experience.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Actual D' costs in SFY 2005 based on MMIS claims data inflated by 7% annually, minus 60% of pharmacy costs to reflect anticipated change in dual eligible person utilization.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Average ICF/MR daily rate times projected waiver days with an 7% annual inflator

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Actual claims data on ICF/MR participant Medicaid costs other than ICF/MR with a 7% annual inflator. 60% of past pharmacy costs are discounted to reflect an approximate 60% dual Medicare/Medicaid population.

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

x	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1 **Unit**	Col. 2 **# Users**	Col. 3 **Avg. Units Per User**	Col. 4 **Avg. Cost/ Unit**	Col. 5 **Total Cost**
Homemaker	Hour	18	310	16	89,280
Personal Care	Hour	210	1175	19	4,688,250
Residential Supports	Month	3521	12	6425	271,469,100
Day Supports	Month	3857	12	900	41,655,600
Supported Employment	Month	193	12	1250	2,895,000
Respite	Month	419	12	185	930,180
Supported Living Arrange.	Month	100	12	1775	2,130,000
PERS	Month	25	12	35	10,500
Specialized Medical Equipment	Item	126	1	1700	214,200
Environmental Modifications	Item	38	1	2800	106,400
Private Duty Nursing	Hour	35	1700	40	2,380,000
Fiscal Management	Month	122	12	150	219,600
Supports Facilitator	Hour	120	10	20	24,000
Participant-Directed Goods and Services	Item	90	2	150	27,000
GRAND TOTAL:					326,839,110
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4,192
FACTOR D (Divide grand total by number of participants)					77,967
AVERAGE LENGTH OF STAY ON THE WAIVER					350

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Homemaker	Hour	18	310	16	89,280
Personal Care	Hour	210	1175	19	4,688,250
Residential Supports	Month	3521	12	6500	274,638,000
Day Supports	Month	3857	12	963	44,571,492
Supported Employment	Month	193	12	1250	2,895,000
Respite	Month	419	12	185	930,180
Supported Living Arrange.	Month	100	12	1775	2,130,000
PERS	Month	25	12	35	10,500
Specialized Medical Equipment	Item	126	1	1750	220,500
Environmental Modifications	Item	38	1	2900	110,200
Private Duty Nursing	Hour	35	1700	40	2,380,000
Fiscal Management	Month	135	12	150	243,000
Supports Facilitator	Hour	130	10	20	26,000
Participant-Directed Goods and Services	Item	90	2	150	27,000
GRAND TOTAL:					332,959,402
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4,192
FACTOR D (Divide grand total by number of participants)					79,427
AVERAGE LENGTH OF STAY ON THE WAIVER					350

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Homemaker	Hour	18	310	16	89,280
Personal Care	Hour	210	1175	19	4,688,250
Residential Supports	Month	3521	12	6875	290,482,500
Day Supports	Month	3857	12	963	44,571,492
Supported Employment	Month	193	12	1250	2,895,000
Respite	Month	419	12	185	930,180
Supported Living Arrange.	Month	100	12	1900	2,280,000
PERS	Month	25	12	35	10,500
Specialized Medical Equipment	Item	126	1	1770	223,020
Environmental Modifications	Item	38	1	2920	110,960
Private Duty Nursing	Hour	35	1700	50	2,975,000
Fiscal Management	Month	135	12	150	243,000
Supports Facilitator	Hour	130	10	20	26,000
Participant-Directed Goods and Services	Item	90	2	150	27,000
GRAND TOTAL:					349,552,182
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4,192
FACTOR D (Divide grand total by number of participants)					83,386
AVERAGE LENGTH OF STAY ON THE WAIVER					350

Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Homemaker	Hour	18	310	17	94,860
Personal Care	Hour	210	1175	21	5,181,750
Residential Supports	Month	3521	12	6925	292,595,100
Day Supports	Month	3857	12	975	45,126,900
Supported Employment	Month	193	12	1250	2,895,000
Respite	Month	419	12	185	930,180
Supported Living Arrange.	Month	100	12	1900	2,280,000
PERS	Month	25	12	35	10,500
Specialized Medical Equipment	Item	126	1	1770	223,020
Environmental Modifications	Item	38	1	2920	110,960
Private Duty Nursing	Hour	35	1700	50	2,975,000
Fiscal Management	Month	135	12	150	243,000
Supports Facilitator	Hour	130	10	20	26,000
Participant-Directed Goods and Services	Item	90	2	150	27,000
GRAND TOTAL:					352,719,270
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4,192
FACTOR D (Divide grand total by number of participants)					84,141
AVERAGE LENGTH OF STAY ON THE WAIVER					350

Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Homemaker	Hour	18	310	17	94,860
Personal Care	Hour	210	1175	21	5,181,750
Residential Supports	Month	3521	12	7000	295,764,000
Day Supports	Month	3857	12	985	45,589,740
Supported Employment	Month	193	12	1275	2,952,900
Respite	Month	419	12	185	930,180
Supported Living Arrange.	Month	100	12	2000	2,400,000
PERS	Month	25	12	35	10,500
Specialized Medical Equipment	Item	126	1	1770	223,020
Environmental Modifications	Item	38	1	2920	110,960
Private Duty Nursing	Hour	35	1700	50	2,975,000
Fiscal Management	Month	135	12	150	243,000
Supports Facilitator	Hour	130	10	20	26,000
Participant-Directed Goods and Services	Item	90	2	150	27,000
GRAND TOTAL:					356,528,910
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4192
FACTOR D (Divide grand total by number of participants)					85,050
AVERAGE LENGTH OF STAY ON THE WAIVER					350